APPENDIX 1

Text of nine Rules proposed for amendment:

11 NCAC 23A .0108

11 NCAC 23A .0109

11 NCAC 23A .0302

11 NCAC 23B .0104

11 NCAC 23B .0105

11 NCAC 23L .0101

11 NCAC 23L .0102

11 NCAC 23L .0103

11 NCAC 23L .0105

11 NCAC 23A .0108 is proposed for amendment as follows:

11 NCAC 23A .0108 ELECTRONIC FILINGS WITH THE COMMISSION; HOW TO FILE

(a) All documents filed with the Commission in workers' compensation cases shall be submitted electronically in accordance with this Rule. Any document transmitted to the Commission in a manner not in accordance with this Rule shall not be accepted for filing. Any document filed with the Commission that requires contemporaneous payment of a processing fee pursuant to Rule 11 NCAC 23E .0203 shall not be deemed filed until the fee has been paid in full. The electronic filing requirements of this Rule shall not apply to ~~employees, medical providers,~~ employees or non-insured employers without legal representation. ~~Employees, medical providers, —~~ Employees and non-insured employers without legal representation may file all documents with the Commission via the Commission's Electronic Document Filing Portal ~~("EDFP"),~~("EDFP") or by sending the documents to the Clerk of the Industrial Commission via electronic ~~mail,~~mail (dockets@ic.nc.gov), facsimile, U.S. Mail, private courier service, or hand delivery.

(b) Except as set forth in Paragraphs (d) and (e) of this Rule, all documents required to be submitted electronically to the Commission shall be filed ~~transmitted to the Commission~~ via EDFP. Information regarding how to ~~register for and~~ use EDFP is available at http://www.ic.nc.gov/training.html. In the event EDFP is inoperable, all documents required to be filed via EDFP shall be transmitted to the Commission via electronic mail to edfp@ic.nc.gov. Documents required to be filed via EDFP that are sent to the Commission via electronic mail when EDFP is operable shall not be accepted for filing.

(c) Transcripts of depositions shall be filed with the Commission pursuant to this Rule by the court reporting service. Transcripts filed with the Commission shall have only one page of text per page and shall include all exhibits. The parties shall provide the Commission's court reporting service with the information necessary to effectuate filing of the deposition transcripts and attached exhibits via EDFP. If an exhibit to a deposition is in a form that makes submission of an electronic copy impracticable, counsel for the party offering the exhibit shall make arrangements with the Commission to facilitate the submission of the exhibit. Condensed transcripts and paper copies of deposition transcripts shall not be accepted for filing.

(d) A Form 19 shall be filed as the first report of injury (FROI) via electronic data interchange (EDI), except in claims involving non-insured ~~employers~~ employers, ~~or~~ in claims for lung disease, in claims with multiple employers or multiple carriers, or in claims with six-character IC file numbers, in which case the Form 19 shall be filed electronically via EDFP ~~to forms@ic.nc.gov, by mail to 1235 Mail Service Center, Raleigh, North Carolina 27699-1235,~~ or as otherwise permitted pursuant to Paragraph (a) of this Rule. Information regarding how to register for and use EDI is available at www.ncicedi.info.

~~(e) The workers' compensation forms and documents listed in Table 1 shall not be required to be transmitted via EDFP provided all applicable qualifying conditions are met.~~

~~Table 1: Forms and documents exempt from EDFP filing requirements and how to file them:~~

~~DOCUMENT~~	~~QUALIFYING CONDITION(S)~~	~~HOW TO FILE~~

~~Form 18~~	~~No IC file number has been assigned~~	~~Electronically to forms@ic.nc.gov, by mail to 1235 Mail Service Center, Raleigh, North Carolina 27699-1235, or as otherwise permitted pursuant to Paragraph (a) of this Rule~~
~~Form 18B~~	~~Always exempt from EDFP filing requirement~~	~~Electronically to forms@ic.nc.gov, by mail to 1235 Mail Service Center, Raleigh, North Carolina 27699-1235, or as otherwise permitted pursuant to Paragraph (a) of this Rule~~
~~Form 51~~	~~Always exempt from EDFP filing requirement~~	~~Electronically to forms@ic.nc.gov~~
~~Plaintiff's Attorney Representation Letter~~	~~No IC file number has been assigned~~	~~Electronically to forms@ic.nc.gov~~
~~Documents to be filed with the Commission's Compliance & Fraud Investigative Division~~	~~Always exempt from EDFP filing requirement~~	~~Electronically to fraudcomplaints@ic.nc.gov or as otherwise permitted pursuant to Paragraph (a) of this Rule~~
~~Documents to be filed with the Commission's Medical Fees Section~~	~~Always exempt from EDFP filing requirement~~	~~Electronically to medicalfees@ic.nc.gov or as otherwise permitted pursuant to Paragraph (a) of this Rule~~
~~Documents to be filed with the Commission's Safety Education & Training Section~~	~~Always exempt from EDFP filing requirement~~	~~Electronically to safety@ic.nc.gov or as otherwise permitted pursuant to Paragraph (a) of this Rule~~
~~A Form 25N to be filed with the Commission's Medical Rehabilitation Nurses Section~~	~~No IC file number has been assigned~~	~~Electronically to 25N@ic.nc.gov~~
~~Rehabilitation referrals to be filed with the Commission's Medical Rehabilitation Nurses Section~~	~~No IC file number has been assigned~~	~~Electronically to rehab.referrals@ic.nc.gov~~

(e) Documents to be filed with the Criminal Investigations & Employee Classification Division regarding fraud complaints shall be submitted electronically to fraudcomplaints@ic.nc.gov. Documents to be filed with the Criminal

Investigations & Employee Classification Division regarding employee misclassification shall be submitted electronically to emp.classification@ic.nc.gov. Safety rules to be filed with the Commission under 11 NCAC 23A .0411 shall be submitted electronically to safety@ic.nc.gov.

(f) A self-insured employer, carrier or guaranty association, third-party administrator, court reporting service, medical provider, or law firm may apply to the Commission for an emergency temporary waiver of the electronic filing requirement set forth in Paragraph (a) of this Rule when it is unable to comply because of temporary technical problems or lack of electronic mail or internet access. The request for an emergency temporary waiver shall be included with any filing submitted via facsimile, U.S. Mail, or hand delivery due to such temporary technical or access issues.

(g) A Notice of Appeal to the North Carolina Court of Appeals shall be accepted for filing by the Commission via ~~EDFP or U.S. Mail.~~ EDFP, U.S. Mail, hand delivery, or any other means allowed by the Rules of Appellate Procedure or applicable statutes governing appeals from the General Courts of Justice. Notwithstanding the foregoing, employees and non-insured employers without legal representation may file all documents with the Commission as provided in Paragraph (a) of this Rule.

History Note: *Authority G.S. 97-80; 97-81; 97-86;*
Eff. February 1, 2016;
Amended Eff. February 1, 2017;
Recodified from 04 NCAC 10A .0108 Eff. June 1, 2018;
Amended Eff. December 1, 2018;
Amended Eff. _____.

11 NCAC 23A .0109 is proposed for amendment as follows:

11 NCAC 23A .0109 CONTACT INFORMATION

(a) "Contact information" for purposes of this Rule shall include telephone number, facsimile number, email address, and mailing address.

(b) All attorneys of record with matters before the Commission shall inform the Commission ~~in writing~~ of any change in the attorney's contact information via ~~email to dockets@ic.nc.gov.~~ the Commission's Electronic Document Filing Portal ("EDFP").

(c) All unrepresented persons or entities with matters before the Commission shall inform the Commission upon any change to their contact information in the following manner:

(1) All employees who are not represented by counsel shall inform the Commission of any change in contact information by filing a written notice via EDFP, ~~the Commission's Electronic Document Filing Portal ("EDFP"),~~ email to forms@ic.nc.gov, facsimile, U.S. Mail, private courier service, or hand delivery.

(2) All non-insured employers that are not represented by counsel shall inform the Commission of any change in contact information by filing a written notice via EDFP, email to dockets@ic.nc.gov, facsimile, U.S. Mail, private courier service, or hand delivery.

History Note: *Authority G.S. 97-80;*
Eff. January 1, 2019;
Amended Eff. _____.

11 NCAC 23A .0302 is proposed for amendment as follows:

11 NCAC 23A .0302 REQUIRED CONTACT INFORMATION FROM CARRIERS

All insurance carriers, third party administrators, and self-insured employers shall designate a primary contact person for workers' compensation issues in North Carolina and shall maintain and provide annually on July 1 to the Director of Claims Administration of the Commission via the Commission's Electronic Document Filing Portal ("EDFP") ~~email at rule302@ic.nc.gov,~~ the primary contact person's current contact information, including direct telephone and facsimile numbers, mailing addresses, and email addresses. Contact information shall be updated within 30 days of any change.

History Note: *Authority G.S. 97-80(a); 97-94;*
Eff. January 1, 2011;
Amended Eff. November 1, 2014;
Recodified from 04 NCAC 10A .0302 Eff. June 1, 2018;
Amended Eff. December 1, 2018;
Amended Eff. _____.

11 NCAC 23B .0104 is proposed for amendment as follows:

11 NCAC 23B .0104 ELECTRONIC FILINGS WITH THE COMMISSION; HOW TO FILE

(a) All filings to the Commission in tort claims shall be submitted electronically in accordance with this Rule. Any document transmitted to the Commission in a manner not in accordance with this Rule shall not be accepted for filing. Plaintiffs without legal representation may file all documents with the Office of the Clerk of the Commission via the Commission's Electronic Document Filing Portal ~~(EDFP),~~ (EDFP) or by sending the documents to the Clerk of the Industrial Commission via electronic ~~mail,~~mail (dockets@ic.nc.gov), facsimile, U.S. Mail, private courier service, or hand delivery.

(b) ~~Except as set forth in Paragraph (c) of this Rule, all documents shall be transmitted to the Commission via EDFP~~. Information regarding how to register for and use EDFP is available at http://www.ic.nc.gov/training.html. In the event EDFP is inoperable, all documents required to be filed via EDFP shall be transmitted to the Commission via electronic mail to edfp@ic.nc.gov. Documents required to be filed via EDFP that are sent to the Commission via electronic mail when EDFP is operable shall not be accepted for filing.

~~(c) The tort claims forms and documents listed in Table 1 shall not be required to be transmitted via EDFP provided all applicable qualifying conditions are met.~~

~~Table 1: Forms and documents exempt from EDFP filing requirements and how to file them:~~

~~DOCUMENT~~	~~QUALIFYING CONDITION(S)~~	~~HOW TO FILE~~
~~Form T 1~~	~~No IC file number has been assigned~~	~~Hand delivery to the Industrial Commission's main office or by mail to 1236 Mail Service Center, Raleigh, North Carolina 27699-1236.~~
~~Form T 3~~	~~No IC file number has been assigned~~	~~Email to dockets@ic.nc.gov, hand delivery to the Industrial Commission's main office, or by mail to 1236 Mail Service Center, Raleigh, North Carolina; 27699-1236~~
~~Pre-affidavit motion under Rule 9(j)(3) of the Rules of Civil Procedure to extend the Statute of Limitations.~~	~~No IC file number has been assigned.~~	~~Hand delivery to the Industrial Commission's main office or by mail to 1236 Mail Service Center, Raleigh, North Carolina 27699-1236.~~

~~(d) A one-year waiver shall be granted to an attorney who notifies the Commission of the attorney's inability to comply with the electronic filing requirements in Paragraph (a) of this Rule due to a lack of the necessary internet technology resources. The notification shall indicate why the attorney is unable to comply with the rule and outline the attorney's plan for coming into compliance within the one year period. The notification shall be filed with the Office of the Clerk of the Commission via facsimile or U.S. Mail. This Paragraph shall expire one year from the effective date of this Rule.~~

(c) ~~(e)~~ Any party may apply to the Commission for an emergency temporary waiver of the electronic filing requirement set forth in Paragraph (a) of this Rule if it is unable to comply because of temporary technical problems or lack of electronic mail or internet access. The request for an emergency temporary waiver shall be included with any filing submitted via facsimile, U.S. Mail, or hand delivery due to such temporary technical or access issues.

(d) ~~(f)~~ A Notice of Appeal to the North Carolina Court of Appeals shall be accepted for filing by the Commission via ~~EDFP or U.S. Mail.~~ EDFP, U.S. Mail, hand delivery, or any other means allowed by the Rules of Appellate Procedure or applicable statutes governing appeals from the General Courts of Justice. Notwithstanding the foregoing, plaintiffs without legal representation may file all documents with the Commission as provided in Paragraph (a) of this Rule.

History Note: *Authority G.S. 143-291; 143-291.2; 143-293; 143-297; 143-300;*
Eff. May 1, 2000;
Amended Eff. July 1, 2014;
Recodified from 04 NCAC 10B .0104 Eff. June 1, 2018;
Amended Eff. March 1, 2019;
Amended Eff. _____.

11 NCAC 23B .0105 is proposed for amendment as follows:

11 NCAC 23B .0105 CONTACT INFORMATION

(a) "Contact information" for purposes of this Rule shall include telephone number, facsimile number, email address, and mailing address.

(b) All persons or entities without legal representation who have matters pending before the Commission shall advise the Commission upon any change in contact information by filing a written notice via the Commission's Electronic Document Filing Portal ("EDFP"), electronic ~~mail,~~mail (dockets@ic.nc.gov), facsimile, U.S. Mail, private courier service, or hand delivery.

(c) A plaintiff without legal representation who was an inmate in the North Carolina Division of Adult Corrections at the time of filing his or her tort claim, shall, within thirty (30) days of release, provide the Commission with written notice of his or her post-release contact information in any manner authorized in Paragraph (b) of this Rule. Following the initial written notice of post-release contact information, the previously incarcerated plaintiff shall continue to advise the Commission upon all changes in contact information in accordance with Paragraph (b) of this Rule.

(d) All attorneys of record with matters before the Commission shall inform the Commission in writing of any change in the attorney's or the represented party's contact information via ~~email to dockets@ic.nc.gov.~~EDFP.

History Note: *Authority G.S. 143-291; 143-300;*
Eff. March 1, 2019;
Amended Eff. _____.

11 NCAC 23L .0101 is proposed for amendment as follows:

SUBCHAPTER 23L – INDUSTRIAL COMMISSION FORMS

SECTION .0100 – WORKERS' COMPENSATION FORMS

11 NCAC 23L .0101 FORM 21 – AGREEMENT FOR COMPENSATION FOR DISABILITY

~~(a) (Effective until July 1, 2015) The parties to a workers' compensation claim shall use the following Form 21, Agreement for Compensation for Disability, for agreements regarding disability and payment of compensation therefor pursuant to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of compensation for permanent partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 21, Agreement for Compensation for Disability, shall read as follows:~~

~~North Carolina Industrial Commission~~
~~Agreement for Compensation for Disability~~
~~(G.S. 97-82)~~

~~IC File # _____~~
~~Emp. Code # _____~~
~~Carrier Code # _____~~
~~Carrier File # _____~~
~~Employer FEIN _____~~

~~The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act~~

~~_____~~
~~Employee's Name~~
~~_____~~
~~Address~~
~~_____~~
~~City State Zip~~
~~_____~~
~~Home Telephone Work Telephone~~
~~Social Security Number: _____ Sex: ☐ M ☐ F Date of Birth: _____~~

~~_____~~

Employer's Name Telephone Number

_____

Employer's Address City State Zip

_____

Insurance Carrier

_____

Carrier's Address City State Zip

_____

Carrier's Telephone Number Carrier's Fax Number

We, The Undersigned, Do Hereby Agree And Stipulate As Follows:

1. All parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and _____ is the carrier/administrator for the employer.

2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on or by _____.

3. The injury by accident or occupational disease resulted in the following injuries: _____

_____.

4. The employee □ was/ □ was not paid for the entire day when the injury occurred.

5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was $_____, subject to verification unless otherwise agreed upon in Item 9 below.

6. Disability resulting from the injury or occupational disease began on _____.

7. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of $_____ per week beginning _____, and continuing for _____ weeks.

8. The employee □ has / □ has not returned to work for _____

on _____, at an average weekly wage of $_____.

9. State any further matters agreed upon, including disfigurement, permanent partial, or temporary partial disability: _____.

10. If applicable, the Second Injury Fund Assessment is $_____. Check □ is □ is not attached.

11. The date of this agreement is _____. Date of first payment: _____ Amount: _____.

12. IMPORTANT NOTICE TO EMPLOYEE: The Industrial Commission's fee for processing this agreement is $300.00 to be paid in equal shares by the employee and the employer. You are not required to pay your portion of the fee in advance, and if your award is $3,000.00 or less, you are not responsible for any portion of the fee. If your award is more than $3,000.00, the employer shall deduct $150.00 from your award, unless you and your employer agree otherwise.

Check one of the boxes below if the award is more than $3,000.00:

□ The employer will deduct $150.00 from the amount to be paid pursuant to this agreement.

□ The employee and employer have agreed that the employer will pay the entire fee.

Name Of Employer Signature Title

Name Of Carrier / Administrator Signature Title

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Pages 1 and 2 of this form.

Signature of Employee Address

Signature of Employee's Attorney Address

North Carolina Industrial Commission

The Foregoing Agreement Is Hereby Approved:

Claims Examiner Date

Attorney's Fee Approved

☐ Check Box If No Attorney Retained.

☐ Check Box If Employee Is In Managed Care.

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

~~IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS~~

~~If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must apply to the Industrial Commission in writing within two years, or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M, Employee's Application for Additional Medical Compensation (G.S. 97-25.1), available at http://www.ic.nc.gov/forms.html.~~

~~IMPORTANT NOTICE TO EMPLOYER~~

~~The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission, or show cause for not submitting the agreement. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.~~

~~NEED ASSISTANCE?~~

~~If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.~~

~~Form 21~~
~~11/2014~~

~~Self-Insured Employer or Carrier, Mail to:~~
~~NCIC - Claims Section~~
~~4335 Mail Service Center~~
~~Raleigh, NC 27699-4335~~
~~Telephone: (919) 807-2502~~
~~Helpline: (800) 688-8349~~
~~Website: http://www.ic.nc.gov/~~

(a) ~~(Effective July 1, 2015)~~ The parties to a workers' compensation claim shall use the following Form 21, *Agreement for Compensation for Disability*, for agreements regarding disability and payment of compensation therefor pursuant to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of compensation for permanent

partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 21, *Agreement for Compensation for Disability*, shall read as follows:

North Carolina Industrial Commission
Agreement for Compensation for Disability
(G.S. 97-82)

IC File # _____
Emp. Code # _____
Carrier Code # _____
Carrier File # _____
Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

_____
Employee's Name
_____
Address
_____
City State Zip
_____
Home Telephone Work Telephone
Last 4 digits of Social Security Number: _____ Sex: □ M □ F Date of Birth: _____

_____
Employer's Name Telephone Number
_____
Employer's Address City State Zip
_____
Insurance Carrier
_____
Carrier's Address City State Zip
_____
Carrier's Telephone Number Carrier's Fax Number

We, The Undersigned, Do Hereby Agree And Stipulate As Follows:

1. All parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and _____ is the carrier/administrator for the employer.

2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on or by _____.

3. The injury by accident or occupational disease resulted in the following injuries: _____ _____.

4. The employee □ was/ □ was not paid for the entire day when the injury occurred.

5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was $_____, subject to verification unless otherwise agreed upon in Item 9 below.

6. Disability resulting from the injury or occupational disease began on _____.

7. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of $_____ per week beginning _____, and continuing for _____ weeks.

8. The employee □ has / □ has not returned to work for _____ on _____ , at an average weekly wage of $_____.

9. State any further matters agreed upon, including disfigurement, permanent partial, or temporary partial disability: _____.

10. If applicable, the Second Injury Fund Assessment is $_____. Check □ is □ is not attached.

11. The date of this agreement is _____. Date of first payment: _____ Amount: _____.

_____

Name Of Employer Signature Title

_____

Name Of Carrier / Administrator Signature Title

By signing I enter into this agreement and certify that I have read the “Important Notices to Employee” printed on Page 2 of this form.

_____

Signature of Employee Address

_____

Signature of Employee's Attorney Address

North Carolina Industrial Commission

The Foregoing Agreement Is Hereby Approved:

_____

Claims Examiner Date

_____

Attorney's Fee Approved

☐ Check Box If No Attorney Retained.

☐ Check Box If Employee Is In Managed Care.

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must ~~apply to the Industrial Commission in writing~~ file an application for additional medical compensation pursuant to G.S. 97-25.1 within two years, or your right to these benefits may be lost. ~~To apply you may also use Industrial Commission Form 18M, Employee's Application for Additional Medical Compensation (G.S. 97-25.1),available at http://www.ic.nc.gov/forms.html.~~ An application for additional medical compensation may be made on a Form 18M Employee's Application for Additional Medical Compensation or by written request. In the alternative, an employee may file an application for additional medical compensation by filing a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission forms are available at https://www.ic.nc.gov/forms.html.

IMPORTANT NOTICE TO EMPLOYER

The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission.~~Commission, or show cause for not submitting the agreement.~~ The employer or carrier/administrator shall file a Form 28B, *Report of Compensation and*

Medical Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.

NEED ASSISTANCE?

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.

Form 21

~~7/2015~~ 7/2020

Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"):~~Carrier, Mail to:~~

~~NCIC - Claims Section~~

~~4335 Mail Service Center~~

~~Raleigh, NC 27699-4335~~

~~Telephone: (919) 807-2502~~

~~Helpline: (800) 688-8349~~

~~Website: http://www.ic.nc.gov/~~

https://www.ic.nc.gov/docfiling.html

Contact Information:

NCIC- Claims Administration

Telephone: (919) 807-2502

Helpline: (800) 688-8349

Website: https://www.ic.nc.gov

(b) The copy of the form described in Paragraph (a) of this Rule can be accessed at ~~http://www.ic.nc.gov/forms/form21.pdf.~~https://www.ic.nc.gov/forms/form21.pdf. The form may be reproduced only in the format available at ~~http://www.ic.nc.gov/forms/form21.pdf~~ https://www.ic.nc.gov/forms/form21.pdf and may not be altered or amended in any way.

History Note: *Authority G.S. 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10L .0101 Eff. June 1, 2018;
Amended Eff. _____.

11 NCAC 23L .0102 is proposed for amendment as follows:

11 NCAC 23L .0102 FORM 26 – SUPPLEMENTAL AGREEMENT AS TO PAYMENT OF COMPENSATION

~~(a) (Effective until July 1, 2015) If the parties to a workers' compensation claim have previously entered into an approved agreement on a Form 21, Agreement for Compensation for Disability, or a Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, they shall use the following Form 26, Supplemental Agreement as to Payment of Compensation, for agreements regarding subsequent additional disability and payment of compensation pursuant to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of compensation for permanent partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 26, Supplemental Agreement as to Payment of Compensation, shall read as follows:~~

~~North Carolina Industrial Commission~~
~~Supplemental Agreement as to Payment~~
~~of Compensation (G.S. §97-82)~~

~~IC File # _____~~
~~Emp. Code # _____~~
~~Carrier Code # _____~~
~~Carrier File # _____~~
~~Employer FEIN _____~~

~~The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act~~

~~_____~~
~~Employee's Name~~
~~_____~~
~~Address~~
~~_____~~
~~City State Zip~~
~~_____~~
~~Home Telephone Work Telephone~~
~~Social Security Number: _____ Sex: ☐ M ☐ F Date of Birth: _____~~

~~_____~~
~~Employer's Name Telephone Number~~

_____

Employer's Address City State Zip

_____

Insurance Carrier

_____

Carrier's Address City State Zip

_____

Carrier's Telephone Number Carrier's Fax Number

We, The Undersigned, Do Hereby Agree and Stipulate As Follows:

1. Date of injury: _____

2. The employee □ returned to work / □ was rated on _____ (date), at a weekly wage of $_____.

3. The employee became totally disabled on _____.

4. Employee's average weekly wage □ was reduced / □ was increased on _____, from $_____ per week to $_____ per week.

5. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of $_____ per week.

Beginning _____, and continuing for_____ weeks. The type of disability compensation is _____.

6. State any further matters agreed upon, including disfigurement or temporary partial disability: _____.

7. IMPORTANT NOTICE TO EMPLOYEE: The Industrial Commission's fee for processing this agreement is $300.00 to be paid in equal shares by the employee and the employer. You are not required to pay your portion of the fee in advance, and if your award is $3,000.00 or less, you are not responsible for any portion of the fee. If your award is more than $3,000.00, the employer shall deduct $150.00 from your award, unless you and your employer agree otherwise.

Check one of the boxes below if the award is more than $3,000.00:

□ The employer will deduct $150.00 from the amount to be paid pursuant to this agreement.

□ The employee and employer have agreed that the employer will pay the entire fee.

8. The date of this agreement is _____.

_____

Name Of Employer Signature Title

_____

Name Of Carrier/Administrator Signature Title

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Pages 1 and 2 of this form.

_____

Signature of Employee Address

_____

Signature of Employee's Attorney Address

☐ Check box if no attorney retained.

North Carolina Industrial Commission

The Foregoing Agreement Is Hereby Approved:

_____

Claims Examiner Date

_____

Attorney's fee approved

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must apply to the Industrial Commission in writing within two years, or your right to these benefits may be lost. To apply you may also use Industrial Commission Form 18M, Employee's Application for Additional Medical Compensation (G.S. 97-25.1), available at http://www.ic.nc.gov/forms.html.

IMPORTANT NOTICE TO EMPLOYER

~~This form shall be used only to supplement Form 21, Agreement for Compensation for Disability (G.S. 97-82), or an award in cases in which subsequent conditions require a modification of a former agreement or award. The employee must be provided a copy of the form when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission, or show cause for not submitting the agreement. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.~~

~~NEED ASSISTANCE?~~

~~If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.~~

~~Form 26~~
~~11/2014~~

~~Self-Insured Employer or Carrier Mail to:~~
~~NCIC - Claims Administration~~
~~4335 Mail Service Center~~
~~Raleigh, North Carolina 27699-4335~~
~~Main Telephone: (919) 807-2500~~
~~Helpline: (800) 688-8349~~
~~Website: http://www.ic.nc.gov/~~

(a) ~~(Effective July 1, 2015)~~ If the parties to a workers' compensation claim have previously entered into an approved agreement on a Form 21, *Agreement for Compensation for Disability*, or a Form 26A, *Employer's Admission of Employee's Right to Permanent Partial Disability*, they shall use the following Form 26, *Supplemental Agreement as to Payment of Compensation*, for agreements regarding subsequent additional disability and payment of compensation pursuant to G.S. 97-29 and 97-30. Additional issues agreed upon by the parties such as payment of compensation for permanent partial disability may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 26, *Supplemental Agreement as to Payment of Compensation*, shall read as follows:

North Carolina Industrial Commission
Supplemental Agreement as to Payment
of Compensation (G.S. §97-82)

IC File # _____

Emp. Code # _____

Carrier Code # _____

Carrier File # _____

Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

_____

Employee's Name

_____

Address

_____

City State Zip

_____

Home Telephone Work Telephone

Last 4 digits of Social Security Number: _____ Sex: □ M □ F Date of Birth: _____

_____

Employer's Name Telephone Number

_____

Employer's Address City State Zip

_____

Insurance Carrier

_____

Carrier's Address City State Zip

_____

Carrier's Telephone Number Carrier's Fax Number

We, The Undersigned, Do Hereby Agree and Stipulate As Follows:

1. Date of injury: _____.
2. The employee □ returned to work / □ was rated on _____ (date), at a weekly wage of $_____.
3. The employee became totally disabled on _____.
4. Employee's average weekly wage □ was reduced / □ was increased on _____, from $_____ per week to $_____ per week.

5. The employer and carrier/administrator hereby undertake to pay compensation to the employee at the rate of $_____ per week.

Beginning _____, and continuing for_____ weeks. The type of disability compensation is _____.

6. State any further matters agreed upon, including disfigurement or temporary partial disability:

_____.

7. The date of this agreement is _____.

_____

Name Of Employer Signature Title

_____

Name Of Carrier/Administrator Signature Title

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Page 2 of this form.

_____

Signature of Employee Address

_____

Signature of Employee's Attorney Address

☐ Check box if no attorney retained.

North Carolina Industrial Commission

The Foregoing Agreement Is Hereby Approved:

_____

Claims Examiner Date

_____

Attorney's fee approved

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must ~~apply to the Industrial Commission in writing~~ file an application for additional medical compensation pursuant to G.S. 97-25.1 within two years, or your right to these benefits may be lost. ~~To apply you may also use Industrial Commission Form 18M, Employee's Application for Additional Medical Compensation (G.S. 97-25.1), available at http://www.ic.nc.gov/forms.html~~. An application for additional medical compensation may be made on a Form 18M Employee's Application for Additional Medical Compensation or by written request. In the alternative, an employee may file an application for additional medical compensation by filing a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission forms are available at https://www.ic.nc.gov/forms.html.

IMPORTANT NOTICE TO EMPLOYER

This form shall be used only to supplement Form 21, *Agreement for Compensation for Disability* (G.S. 97-82), or an award in cases in which subsequent conditions require a modification of a former agreement or award. The employee must be provided a copy of the form when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission. ~~Commission, or show cause for not submitting the agreement.~~ The employer or carrier/administrator shall file a Form 28B, *Report of Compensation and Medical Compensation Paid*, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.

NEED ASSISTANCE?

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.

Form 26

~~7/2015~~7/2020

Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"):~~Carrier Mail to: NCIC - Claims Administration~~

~~4335 Mail Service Center~~
~~Raleigh, North Carolina 27699-4335~~
~~Main Telephone: (919) 807-2500~~
~~Helpline: (800) 688-8349~~
~~Website: http://www.ic.nc.gov/~~
https://www.ic.nc.gov/docfiling.html
Contact Information:
NCIC- Claims Administration
Telephone: (919) 807-2502
Helpline: (800) 688-8349
Website: https://www.ic.nc.gov

(b) The copy of the form described in Paragraph (a) of this Rule can be accessed at ~~http://www.ic.nc.gov/forms/form26.pdf.~~https://www.ic.nc.gov/forms/form26.pdf. The form may be reproduced only in the format available at ~~http://www.ic.nc.gov/forms/form26.pdf~~ https://www.ic.nc.gov/forms/form26.pdf and may not be altered or amended in any way.

History Note: *Authority G.S. 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10L .0102 Eff. June 1, 2018;
Amended Eff. _____.

11 NCAC 23L .0103 is proposed for amendment as follows:

11 NCAC 23L .0103 FORM 26A – EMPLOYER'S ADMISSION OF EMPLOYEE'S RIGHT TO PERMANENT PARTIAL DISABILITY

~~*(a) (Effective until July 1, 2015)The parties to a workers' compensation claim shall use the following Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, for agreements regarding the employee's entitlement to and the employer's payment of compensation for permanent partial disability pursuant to G.S. 97-31. Additional issues agreed upon by the parties, such as election of payment of temporary partial disability pursuant to G.S. 97-30, may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 26A, Employer's Admission of Employee's Right to Permanent Partial Disability, shall read as follows:*~~

~~*North Carolina Industrial Commission*~~
~~*Employer's Admission of Employee's Right to Permanent Partial Disability*~~
~~*(G.S. §97-31)*~~

~~*IC File #* _____~~
~~*Emp. Code #* _____~~
~~*Carrier Code #* _____~~
~~*Carrier File #* _____~~
~~*Employer FEIN* _____~~

~~*The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act*~~

_____
~~*Employee's Name*~~
_____
~~*Address*~~
_____
~~*City State Zip*~~
_____
~~*Home Telephone Work Telephone*~~
~~*Social Security Number:* _____ *Sex:* ☐ *M* ☐ *F Date of Birth:* _____~~

_____
~~*Employer's Name Telephone Number*~~
_____

~~*Employer's Address City State Zip*~~

~~_____~~

~~*Insurance Carrier*~~

~~_____~~

~~*Carrier's Address City State Zip*~~

~~_____~~

~~*Carrier's Telephone Number Carrier's Fax Number*~~

~~*WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:*~~

~~*1. All the parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and _____ is the Carrier/Administrator for the Employer.*~~

~~*2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on _____.*~~

~~*3. The injury by accident or occupational disease resulted in the following injuries: _____.*~~

~~*4. The employee □ was □ was not paid for the 7 day waiting period.*~~

~~*If not, was salary continued? □ yes □ no. Was employee paid for the date of injury? □ yes □ no*~~

~~*5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was $_____. This results in a weekly compensation rate of $_____.*~~

~~*6. The employee □ has □ has not returned full time to work for _____ on _____, at an average weekly wage of $_____.*~~

~~*7. Claimant was released □ with permanent restrictions □ without permanent restrictions.*~~

~~*8. Permanent partial disability compensation will be paid to the injured worker as follows:*~~

~~*____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)*~~

~~*____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)*~~

~~*____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)*~~

~~*Total amount of permanent partial disability compensation is $_____. Date of first payment:_____.*~~

~~*9. State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial disability, waiting period or other: _____.*~~

~~*10. An overpayment is claimed in the amount of $_____. Overpayment was calculated as follows:_____.*~~

~~*If overpayment claimed, a Form 28B, Report of Compensation and Medical Compensation Paid, is attached. □ yes □ no*~~

~~*11. If applicable, the Second Injury Fund Assessment is $ _____. A check □ is □ is not included.*~~

~~12. IMPORTANT NOTICE TO EMPLOYEE: The Industrial Commission's fee for processing this agreement is $300.00 to be paid in equal shares by the employee and the employer. You are not required to pay your portion of the fee in advance, and if your award is $3,000.00 or less, you are not responsible for any portion of the fee. If your award is more than $3,000.00, the employer shall deduct $150.00 from your award, unless you and your employer agree otherwise.~~

~~Check one of the boxes below if the award is more than $3,000.00:~~

~~☐ The employer will deduct $150.00 from the amount to be paid pursuant to this agreement.~~

~~☐ The employee and employer have agreed that the employer will pay the entire fee.~~

~~The undersigned hereby certify that the material medical and vocational reports related to the injury have been provided to the employee or the employee's attorney and have been filed with the Industrial Commission for consideration pursuant to G.S. 97-82(a) and Rule 11 NCAC 23A .0501.~~

~~Name Of Employer Signature Title Date~~

~~Name Of Carrier/Administrator Signature Direct Phone Number Title Date~~

~~By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on pages 2 and 3 of this form.~~

~~Signature of Employee Address Date~~

~~Signature of Employee's Attorney Address Date~~

~~☐ Check box if no attorney retained.~~

~~North Carolina Industrial Commission~~
~~The Foregoing Agreement Is Hereby Approved:~~

~~Claims Examiner Date~~

~~Attorney's fee approved~~

~~IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS~~

~~*Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.*~~

~~*IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS*~~

~~*If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.*~~

~~*IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS*~~

~~*If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must apply to the Industrial Commission in writing within two years, or your right to these benefits may be lost. To apply you may also use Industrial Commission 18M, Employee's Application for Additional Medical Compensation (G.S. 97-25.1), available at http://www.ic.nc.gov/forms.html.*~~

~~*IMPORTANT NOTICE TO EMPLOYER*~~

~~*The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission, or show cause for not submitting the agreement. The employer or carrier/administrator shall file a Form 28B, Report of Compensation and Medical Compensation Paid, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.*~~

~~*NEED ASSISTANCE?*~~

~~*If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.*~~

~~*Form 26A*~~

~~*11/2014*~~

~~*Self Insured Employer or Carrier Mail to:*~~

~~*NCIC - Claims Administration*~~

~~*4335 Mail Service Center*~~

~~*Raleigh, North Carolina 27699-4335*~~

~~*Main Telephone: (919) 807-2500*~~

~~*Helpline: (800) 688-8349*~~

~~*Website: http://www.ic.nc.gov/*~~

(a) ~~*(Effective July 1, 2015)*~~ The parties to a workers' compensation claim shall use the following Form 26A, *Employer's Admission of Employee's Right to Permanent Partial Disability*, for agreements regarding the employee's entitlement to and the employer's payment of compensation for permanent partial disability pursuant to G.S. 97-31. Additional issues agreed upon by the parties, such as election of payment of temporary partial disability pursuant to G.S. 97-30, may also be included on the form. This form is necessary to comply with Rule 11 NCAC 23A .0501, where applicable. The Form 26A, *Employer's Admission of Employee's Right to Permanent Partial Disability*, shall read as follows:

North Carolina Industrial Commission
Employer's Admission of Employee's Right to Permanent Partial Disability
(G.S. §97-31)

IC File # _____
Emp. Code # _____
Carrier Code # _____
Carrier File # _____
Employer FEIN _____

The Use Of This Form Is Required Under The Provisions of The Workers' Compensation Act

_____
Employee's Name
_____
Address
_____
City State Zip
_____
Home Telephone Work Telephone
Last 4 digits of Social Security Number: _____ Sex: □ M □ F Date of Birth: _____

_____
Employer's Name Telephone Number
_____
Employer's Address City State Zip

_____

Insurance Carrier

_____

Carrier's Address City State Zip

_____

Carrier's Telephone Number Carrier's Fax Number

WE, THE UNDERSIGNED, DO HEREBY AGREE AND STIPULATE AS FOLLOWS:

1. All the parties hereto are subject to and bound by the provisions of the Workers' Compensation Act and _____ is the Carrier/Administrator for the Employer.

2. The employee sustained an injury by accident or the employee contracted an occupational disease arising out of and in the course of employment on _____.

3. The injury by accident or occupational disease resulted in the following injuries: _____.

4. The employee □ was □ was not paid for the 7 day waiting period.

If not, was salary continued? □ yes □ no. Was employee paid for the date of injury? □ yes □ no

5. The average weekly wage of the employee at the time of the injury, including overtime and all allowances, was $_____. This results in a weekly compensation rate of $_____.

6. The employee □ has □ has not returned full time to work for _____ on _____, at an average weekly wage of $_____.

7. Claimant was released □ with permanent restrictions □ without permanent restrictions. *If claimant was released with permanent restrictions and has returned to work for the employer of injury, attach a job description if known to exist.*

8. Permanent partial disability compensation will be paid to the injured worker as follows:

____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)

____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)

____ weeks of compensation at rate of $_____ per week for ____% rating to _____ (body part)

Total amount of permanent partial disability compensation is $_____. Date of first payment:_____.

9. State any further matters agreed upon, including disfigurement, loss of teeth, election of temporary partial disability, waiting period or other: _____.

10. An overpayment is claimed in the amount of $_____. Overpayment was calculated as follows:_____.

If overpayment claimed, a Form 28B, *Report of Compensation and Medical Compensation Paid*, is attached. □ yes □ no

11. If applicable, the Second Injury Fund Assessment is $ _____. A check □ is □ is not included.

The undersigned hereby certify that the material medical and vocational ~~*reports*~~ *records* related to the ~~*injury*~~ *injury, including any job description known to exist if the employee has permanent restrictions and has returned to work for the employer of injury,* have been provided to the employee or the employee's attorney and have been filed with the Industrial Commission for consideration pursuant to G.S. 97-82(a) and Rule 11 NCAC 23A .0501.

Name Of Employer	Signature	Title	Date

Name Of Carrier/Administrator	Signature	Direct Phone Number	*Email Address*	Title	Date

By signing I enter into this agreement and certify that I have read the "Important Notices to Employee" printed on Page 3 of this form.

Signature of Employee	Address	*Email Address*	Date

Signature of Employee's Attorney	Address	*Email Address*	Date

☐ Check box if no attorney retained.

North Carolina Industrial Commission
The Foregoing Agreement Is Hereby Approved:

Claims Examiner	Date

Attorney's fee approved

IMPORTANT NOTICE TO EMPLOYEE CLAIMING ADDITIONAL WEEKLY CHECKS OR LUMP SUM PAYMENTS

Once your compensation checks have been stopped, if you claim further compensation, you must notify the Industrial Commission in writing within two years from the date of receipt of your last compensation check or your rights to these benefits may be lost.

IMPORTANT NOTICE TO EMPLOYEE INJURED BEFORE JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred before July 5, 1994, you are entitled to medical compensation as long as it is reasonably necessary, related to your workers' compensation case, and authorized by the carrier or the Industrial Commission.

IMPORTANT NOTICE TO EMPLOYEE INJURED ON OR AFTER JULY 5, 1994 CLAIMING ADDITIONAL MEDICAL BENEFITS

If your injury occurred on or after July 5, 1994, your right to future medical compensation will depend on several factors. Your right to payment of future medical compensation will terminate two years after your employer or carrier/administrator last pays any medical compensation or other compensation, whichever occurs last. If you think you will need future medical compensation, you must ~~apply to the Industrial Commission in writing~~ file an application for additional medical compensation pursuant to G.S. 97-25.1 within two years, or your right to these benefits may be lost. ~~To apply you may also use Industrial Commission 18M, Employee's Application for Additional Medical Compensation (G.S. 97-25.1), available at http://www.ic.nc.gov/forms.html.~~ An application for additional medical compensation may be made on a Form 18M Employee's Application for Additional Medical Compensation or by written request. In the alternative, an employee may file an application for additional medical compensation by filing a Form 33 Request that Claim be Assigned for Hearing pursuant to 11 NCAC 23A .0602. All Industrial Commission forms are available at https://www.ic.nc.gov/forms.html.

IMPORTANT NOTICE TO EMPLOYER

The employee must be provided a copy when the agreement is signed by the employee. Pursuant to Rule 11 NCAC 23A .0501, within 20 days after receipt of the agreement executed by the employee, the employer or carrier/administrator must submit the agreement to the Industrial Commission.~~Commission, or show cause for not submitting the agreement.~~ The employer or carrier/administrator shall file a Form 28B, *Report of Compensation and Medical Compensation Paid*, within 16 days after the last payment made pursuant to this agreement or be subject to a penalty.

NEED ASSISTANCE?

If you have questions or need help and you do not have an attorney, you may contact the Industrial Commission at (800) 688-8349.

Form 26A

~~*7/2015* *6/2020*~~7/2020

Self-Insured Employer or Carrier, File via Electronic Document Filing Portal ("EDFP"): ~~Carrier Mail to:~~

~~NCIC - Claims Administration~~

~~4335 Mail Service Center~~

~~Raleigh, North Carolina 27699-4335~~

~~Main Telephone: (919) 807-2500~~

~~Helpline: (800) 688-8349~~

~~Website: http://www.ic.nc.gov/~~

https://www.ic.nc.gov/docfiling.html

Contact Information:

NCIC- Claims Administration

Telephone: (919) 807-2502

Helpline: (800) 688-8349

Website: https://www.ic.nc.gov

(b) A copy of the form described in Paragraph (a) of this Rule can be accessed at ~~http://www.ic.nc.gov/forms/form26a.pdf.~~https://www.ic.nc.gov/forms/form26a.pdf. The form may be reproduced only in the format available at ~~http://www.ic.nc.gov/forms/form26a.pdf~~ https://www.ic.nc.gov/forms/form26a.pdf and may not be altered or amended in any way.

History Note: *Authority G.S. 97-30; 97-31; 97-73; 97-80(a); 97-81(a); 97-82; S.L. 2014-77;*
Eff. November 1, 2014;
Recodified from 04 NCAC 10L .0103 Eff. June 1, 2018;
Amended Eff. _____*;*
Amended Eff. _____.

11 NCAC 23L .0105 is proposed for amendment as follows:

11 NCAC 23L .0105 FORM T-42 – APPLICATION FOR APPOINTMENT OF GUARDIAN AD LITEM

(a) Persons seeking to appear on behalf of an infant or incompetent shall apply on a Form T-42, Application for Appointment of Guardian Ad Litem, in accordance with Rule 11 NCAC 23B .0203. The Form T-42, Application for Appointment of Guardian Ad Litem, shall read as follows:

North Carolina Industrial Commission
IC File # TA- _____
Application for Appointment of Guardian Ad Litem
The use of this Form is required under Rule 11 NCAC 23B .0203

_____ Plaintiff(s) v. _____Defendant(s)

To the North Carolina Industrial Commission:

The undersigned _____ respectfully shows unto the North Carolina Industrial Commission that _____ is an __ infant or __ incompetent without general or testamentary guardian in this State, and that by reason thereof can bring an action only by a guardian ad litem; that the infant or incompetent has a cause of action against the defendants on account of the following matter and things:

_____

The undersigned is a reputable person closely connected with the infant or incompetent having the relationship with the infant or incompetent as follows: _____

Wherefore, the undersigned prays the Commission that a fit and proper person be appointed Guardian Ad Litem for the infant or incompetent for the purpose of bringing on his or her behalf an action as above set out.

Signature of Applicant _____ Date_____

(Please complete page 2 of form)

Order Appointing Guardian Ad Litem

It appearing to the North Carolina Industrial Commission from the above application that _____ is an __ infant or __ incompetent having no general or testamentary guardian within this State and that said infant or incompetent appears to have a good cause of action against the defendant(s); and it further appearing to the Commission after due inquiry that _____ is a fit and proper person to be appointed guardian ad litem for the infant or incompetent for the purpose of bringing this action on his or her behalf;

It is therefore ordered that _____ be and is hereby appointed guardian ad litem of _____ to bring action on his or her behalf.

This _____ day of _____.

~~Commissioner or Deputy Commissioner~~ Commissioner, Deputy Commissioner, or Executive Secretary

_____

Please type or print:

Full name and address of minor or incompetent:

_____

Birth date of minor: _____

Full name and address of proposed guardian ad litem:

_____

Important Information for Parties

Parties should take notice of the provisions set forth in Rule 11 NCAC 23B .0203.

11 NCAC 23B .0203 Infants and Incompetents

(a) Persons seeking to appear on behalf of an infant or incompetent, in accordance with G.S. 1A-1, Rule 17, shall apply on a Form T-42 Application for Appointment of Guardian ad Litem. The Commission shall appoint a fit and proper person as guardian ad litem, if the Commission determines it to be in the best interest of the minor or incompetent. The Commission shall appoint the guardian ad litem only after due inquiry as to the fitness of the person to be appointed.

(b) The Commission may assess a fee to be paid to an attorney who serves as a guardian ad litem for actual services rendered upon receipt of an affidavit of actual time spent in representation of the minor or incompetent as part of the costs.

ATTORNEYS: File via Electronic Document Filing Portal ("EDFP")

https://www.ic.nc.gov/docfiling.html

UNREPRESENTED PLAINTIFFS: File via EDFP, https://www.ic.nc.gov/docfiling.html OR

Mail to: Industrial Commission Clerk's Office, 1236 Mail Service Center, Raleigh NC 27699-1236 OR

File via hand delivery: Business days from 8 a.m. – 5 p.m., Dobbs Building, 6th floor, 430 N. Salisbury Street, Raleigh NC 27603.

~~SEND TO:~~

~~dockets@ic.nc.gov~~

~~Office of the Clerk~~

~~1236 Mail Service Center~~

~~Raleigh, NC 27699-1236~~

~~Main telephone: (919) 807-2500~~

~~Helpline (800) 688-8349~~

~~Website: http://www.ic.nc.gov~~

FORM T-42

(b) A copy of the form described in Paragraph (a) of this Rule can be accessed at ~~http://www.ic.nc.gov/formt42.pdf.~~https://www.ic.nc.gov/forms/formt-42.pdf. The form shall be reproduced only in the format available at ~~http://www.ic.nc.ogv/forms/formt42.pdf~~ https://www.ic.nc.gov/forms/formt-42.pdf and shall not be altered or amended in any way.

History Note: *Authority G.S. 143-291; 143-295; 143-300;*
Eff. March 1, 2019;
Amended Eff. _____.